POSTPARTUM PSYCHOSES IN THE MALE*

ARNOLD BUCOVE

Psychiatric Service, St. Luke's Hospital, New York, N. Y.

UNTIL recent years, "postpartum" was one of the major categories by which psychoses were characterized in the female. Ebaugh[1] states that close analysis of these cases show that they fall into regular reaction types of mental disease; that no distinct clinical designation is needed. The current American Psychiatric Association nomenclature has no special designation for postpartum psychoses, and the current standard practice is usually to designate cases of what might have been called "postpartum psychoses" as "schizophrenic reaction, acute, undifferentiated type" or "manic depressive reaction." However, Hamilton[2] in his recent and extensive study of female postpartum psychiatric problems declares, "puerperal patients with dissociative syndromes differ from the great mass of schizophrenic patients in several respects." According to Hamilton, postpartum psychotics are usually not noted to have had premorbid symptoms. Hamilton believes that postpartum psychotics often have a capacity to think at times with considerable degree of logic and the intermittent ability to relate to other people. He describes postpartum dissociation as mostly ideational with a large proportion of paranoid diagnoses in early cases. Postpartum cases often have elements of delirious and/or affective syndromes. Postpartum psychotics are more likely to have a sudden clearance than nonpuerperal schizophrenia but, for the entire group of postpartum psychotics, the prognosis is poorer than nonpostpartum schizophrenics. However, Hamilton considered these factors characteristic of "postpartum dissociative syndromes," but they can be found in abundance among nonpostpartum schizophrenic and manic depressive reactions as well.

Hamilton reports that severe postpartum psychiatric illness follows about one in a thousand pregnancies, and much has been written about

* Presented at the meeting of the Section on Neurology and Psychiatry at The New York Academy of Medicine, April 14, 1964.

this area of psychiatric illness. The recent hospitalization of a man (Case I, see below) who became psychotic within two weeks after the birth of his first child brought up the question of postpartum psychoses in males. However, an extensive review of the literature and contact with leading psychiatrists familiar with the literature revealed how little has been written on the subject. Zilboorg[3] wrote that postpartum psychoses do occur in males, but his description of "psychotic reactions" to parenthood in males is mainly elaborated as "depressive reactions." However, Zilboorg maintained that his studies of depressive cases hardly ever failed to show signs of paranoid trends or other schizophrenic mechanisms. Wainwright,[4] in a paper that includes a reference to our three cases, has described a case of male postpartum psychosis with a paranoid delusional system. Jarvis[5] documents an extreme change in behavior in a male after the birth of his child. This change in behavior was held to be analogous to female cases classified as postpartum psychoses. Jarvis wrote, "We have been accustomed to considering childhood, adolescence, and climacterium as points of flux in the dynamic relations of the psyche. I suggest that pregnancy is also one of those crucial times for the male, as well as for the female."

"Couvade" is a well-documented phenomenon in which the male at the time of the birth of his child retires to his bed and goes through the motions of labor and receives attention appropriate to someone in labor. Couvade was known in ancient Greece and was observed by Marco Polo in Chinese Turkistan.[6] It has been found in China, India, Vietnam, Borneo, Thailand, Africa, and the Americas. Among the Mohave Indians, the transvestite men mimic pregnancy and childbirth and go aside from the camp to be ceremonially delivered of stones.[7] Among American Indians the expectant father must take care in his habits to protect the forthcoming child from harm.[6] Zilboorg[3] wrote: "Couvade is an expression of a passive feminine attitude universally developed towards the father in the flight from incest of the Oedipal Complex, by identifying with the mother to save her for himself." Zilboorg reports strong feminine cravings even in the analysis of normal people.

I do not regard postpartum psychiatric illness as a separate entity. Pregnancy is regarded as a stress on the mental equilibrium of both the mother and father that may reactivate earlier conflicts to the extent

of producing severe mental illness. This paper will describe and discuss the psychotic reactions of three men to their wives' pregnancies.

Report of Three Cases of Postpartum Psychoses in Males

I. F. E. is a 39-year-old European nonpracticing Jewish refugee, married 13 years, who was currently doing experimental work for a dissertation in chemistry at a large university. He was admitted to St. Luke's Hospital two weeks after the birth of his first child, a son. He attributed his not having had a child previously to his impecunious status in Europe, although both he and his wife had worked as chemists. His wife had had four or five illicit abortions in Europe. He blamed his wife's pregnancies on the unavailability of contraceptive devices in his native country. Finally, he and his wife had decided to have a child, as they felt his wife was growing too old (she was 39 years of age) to delay further, and the patient expected to complete his Ph.D. thesis in about a year. His wife was asymptomatic through pregnancy. Two months prior to the birth of his child, F. E. became quite anxious regarding a pain in the right upper quadrant of his abdomen. He eventually attributed this pain to liver poisoning from compound X, a solvent necessary for the completion of an experiment for his Ph.D. dissertation. Compound X does produce liver pathology, but a work-up in the student health service was negative. He discounted the negative work-up but decided he must "hold himself together" until the birth of his baby. At about the time of the birth of his baby, F. E. became convinced that he had liver cancer. His reasons for believing that he had liver cancer were as follows:

1) About 1945, while in a prisoner-of-war camp, he had had a severe case of diarrhea that he believed was typhoid, and "this was a long enough latent period."
2) He had "compound-X poisoning of the liver."
3) An x ray had been taken in the investigation of the "compound-X poisoning," and "x ray causes cancer."
4) He had pain in the right upper quadrant of the abdomen.

He also began to believe that he was going "insane" as a result of "compound-X poisoning." By "insanity" he meant "losing control" of himself, although he did not know what he might do if he should lose control. His reasoning for believing he had impending insanity was as follows:

1) "Lead produces liver poisoning." "Compound X produces liver poisoning."
2) "Lead produces brain poisoning." "Compound X must produce brain poisoning."
3) "I have compound-X poisoning, so I must have brain poisoning."
4) "Therefore, I must be going insane because of the compound-X poisoning."

However, it was the complaint of "restlessness" of two weeks' duration that caused F. E. to seek admission. He denied that his "restlessness" was related to his fear of cancer, to the birth of his son, or to his fear of "losing control." After four days of hospitalization, he was discharged at his own demand because of his dissatisfaction with his lack of improvement. He was treated at home by his psychiatrist with dosages of Thorazine exceeding 1,000 mg. per day. Twenty days after his discharge, the patient was readmitted due to his intolerable anxiety. He felt "useless" and thought himself to be in his "wife's way." He reported that he could not take care of his baby because holding the baby made him too "nervous" but later changed "nervous" to "bored."

Past History

Our patient was his family's first child. When he was one year of age, the patient's father deserted the family and spent the rest of his life as a "village idler." F.E. has a few vague childhood memories of short visits to his father, after his desertion of the family. His mother remarried when F. E. was five years of age. When F. E. was eight years of age, his mother gave birth to a daughter, her second and last child. The family showered attention on his sister and virtually ignored the boy. When the patient misbehaved as a youngster, various members of the family would tell him, "Be good; you have no father." However, he denies resentment of this treatment and believes it was "inevitable." One of his earliest memories of childhood was his immediate feelings of dislike for his stepfather on their first meeting. His stepfather is described as a tyrannical type who "looked and acted like Mussolini." When F. E. was in his early teens, his stepfather admitted having married his mother for her dowry. At the time of the Nazi occupation, his stepfather was outside of the country and

remained hidden during the war. His mother was an anxious woman who constantly busied herself with the household chores and gave less than desired attention to him. He reports that when the Nazis finally came to take her to a concentration camp, she was busily tidying her house, which had been crammed with 40 Jews; she was exterminated in a concentration camp. During the war, F. E. was conscripted into a labor battalion and thereby saved from the concentration camps. After the war he supported himself as a student and obtained an undergraduate degree in chemistry. F. E. denies any difficulties during his 13 years of marriage except for one incident in 1956, when his wife threatened to leave him for another man. He became extremely anxious at that time, and he reports that his "nervousness" was controlled by his being drafted into the army, where the discipline of army life helped him control his anxiety. His wife finally decided that she did not love the other man and remained with him. F. E. had had a few premarital and extramarital heterosexual relationships, and he denies any homosexual relationships or ideation.

Course in Hospital

After admission, F. E.'s medication was gradually raised to 2,400 mg. of Thorazine per day, supplemented by Artane. However, the Thorazine had to be reduced to 400 mg. per day two weeks following admission after a seizure in the hospital (there was no history of seizures). In the first weeks of admission, the patient suffered a persistent, unexplainable, and undirected "rage." He also complained of periods of "intolerable restlessness." These periods of restlessness were ameliorated by treatment with intramuscular Thorazine. The first weekend his resident psychiatrist was off duty. F. E. accused the nurses of injecting him with an empty syringe and accused his resident, the following Monday, of "having deceived me." The patient's symptoms abated in a course of psychotherapy plus Thorazine and Stelazine, which was later changed to Stelazine and Tofranil (a depression appeared as the patient's anxiety and rage decreased).

During hospitalization, F. E. was seen in psychotherapy four to five times a week. Attempts to reach the patient's underlying feelings and attitudes were met with tremendous resistance. He saw himself as a victim of compound-X poisoning. He saw his anxiety as an appropriate response to compound-X poisoning, which was produc-

ing liver poisoning, possible liver cancer, and potential "insanity." His "restlessness," "rage," and inability to concentrate were regarded as rootless entities having no origin in his psychological being. He denied any feelings other than joy in regard to his new son and wife. He was "looking forward" to graduating and to embarking on a new career. All attempts to suggest his rage might be directed at his son, thus accounting for his fear of handling his son, or to interpret his feelings of depression and restlessness as a product of attitudes regarding the son and his own new career were unequivocally denied. His fear of compound-X poisoning was respected, but he was told that an extensive chemical analysis of his blood was negative and that his symptoms were not those of compound-X poisoning. It was explained that it was quite impossible to have "liver pain" from compound-X poisoning without positive liver chemistries. When F. E. asked for the apropriate symptoms of compound-X poisoning he was told in good humor that he would not be told the symptoms of such poisoning lest he develop them. He was told should he develop the "right symptoms" for compound X, he would be informed of this development. He accepted this explanation in good humor. The patient was given much support in his trials. He was encouraged and urged to make gradual moves toward handling his son and toward returning to work. Each small success was rewarded with praise. F. E. frequently expressed his appreciation for the greater attention from his resident psychiatrist in contrast to the lesser time given to him originally by his private practitioner. F. E. originally added a sleeping medication containing a small dose of scopolamine (2.5 mg. per day) to the regime of Thorazine prescribed by his private psychiatrist. The private psychiatrist repeatedly reprimanded the patient for taking the scopolamine, although F. E. believed that only the scopolamine enabled him to tolerate his "restlessness." His resident agreed to add acceptable quantities of scopolamine (1.6 mg. per day) to the other medication, and the patient responded very favorably to this acceptance of his demands. It is likely that a strong positive transference was important to the successful treatment of this case. With the birth of his child, F. E. had become a child requiring much care.

After approximately one month of hospitalization, the patient returned to work while remaining an inpatient and, gradually but anxiously, he began to work with compound X again. After 45 days of

hospitalization, the patient was discharged with minimal depression and very persistent feelings that perhaps he might have compound-X poisoning in spite of overwhelming evidence to the contrary. The patient was discharged on Stelazine and Tofranil, and he continued in psychotherapy as an outpatient. He achieved further improvement in relief of his symptoms, which gradually began to diminish, and then discontinued medication against advice because of his fear of becoming "dependent on medication." One month after discharge, the patient began to have an exacerbation of the right upper quadrant pain and became more and more convinced that he was suffering from compound-X poisoning. He complained of weakness, and his work became more irregular one month and a half after discharge. Three months after discharge he was again quite convinced he had compound-X poisoning, and he was advised to see an internist.

After a medical work-up proved negative, he stopped complaining of liver problems but then complained of "stomach" problems and other somatic symptoms. As of now, seven months after discharge, he has worked regularly for the last three months. His family and professional life appear to be without friction. He considers himself a "well man," but very mild somatic complaints continue.

II. A. F. was a graduate of a United States service academy. Before his illness, he had difficulties with premature ejaculations. His wife had his first and only child after five years of marriage. Shortly after the birth of the baby, he developed delusions that people were referring to him as a homosexual. He had abdominal pains, diffuse in nature but no organic disease, and complained of being bloated and full. He took to bed because of fatigability, and his wife had to care for him. He thought that the baby was a product of an illegitimate relationship of his wife. His illness was treated only by psychotherapy, as it occurred before the development of phenothiazines. He reintegrated in approximately three months. A. F. became an alcoholic, yet during World War II he served with honor and distinction. After the war he committed suicide, but we have no information regarding his history between World War II and the suicide.

III. The third patient, T. R., was a 31-year-old Protestant mathematician. Two months prior to admission, his wife had her first baby after nine months of marriage. One week prior to admission, his wife was hospitalized for a postpartum psychosis with suicidal ideation.

Subsequent to his wife's hospitalization, T. R. became markedly anxious. He worked feverishly on his mathematical research project to relieve his anxiety. On the afternoon of his admission, he was supposed to visit his wife at the psychiatric hospital. When the time came to see her, he walked out; subsequently he was found wandering around in a confused state. When brought to the hospital, he was hostile, frightened, and somewhat confused in his orientation. He believed that his wife was dead. He experienced delusions of world destruction including the death of his loved ones. He expressed the idea that he was a superbeing of some kind whose job it was to rehabilitate the world following its destruction. He had numerous ideas of reference and expressed much paranoid ideation. He was treated with psychotherapy supplemented by 600 mg. of Thorazine and 20 mg. of Librium per day. He reintegrated and was discharged in a month's time. He was followed as an outpatient and treated with psychotherapy plus lower doses of Thorazine. In the weeks after discharge, it became apparent that the patient's adjustment was somewhat tenuous. He broke treatment and left New York after a few weeks of treatment. He wrote in a recent letter (two years after discharge), "I am functioning as well or better than I ever have." He did suffer from a depression following his psychosis. He has been in psychotherapy and on Trilafon.

Discussion

Zilboorg[3] proposed that strong incestuous drives made fathers unconsciously guilty about parenthood. He thought his patients were characterized by strong maternal attachment and therefore a strong castration fear and desire for passivity (homosexuality); thus they would conceive of the child as a product of primordial sin. One way of escaping from this sin would be by projection: by the patient's denying his own fatherhood and by accusing his wife of deceiving him, or by other paranoid manifestations. Zilboorg explained much of the paternal hostility to the new child as a rivalry between child and father for the wife-mother.

There is a striking theme of paranoia in the cases of postpartum psychoses in the males reported here. Two of our three cases are schizophrenic reactions, paranoid type. Hamilton[2] found paranoia a frequent feature of his cases of postpartum psychoses in females.

Freud[8] first postulated the connection between paranoia and homosexuality in the Schreiber case. Many psychiatrists have subscribed to the universality of homosexual conflicts in cases of paranoia. However, Klein and Horowitz[9] found homosexual content in only one fifth of a randomly selected group of 40 paranoid men and 40 paranoid women. Oversey[10] has demonstrated that anxieties about homosexuality and paranoid phenomena can arise from nonsexual adaptations (namely, dependency and power strivings) as well as from sexual conflicts.

Only F.E. is known personally to me, and I can discuss his case in detail. The description of the patient's father as one who had deserted his family and spent his life as a "village idler" is so out-of-character for a European Jew that one must suspect the existence of schizophrenia in the father, which would provide a genetic basis for the patient's schizophrenia. The patient's mother had a history of obsessional characteristics, and these defense mechanisms were probably acquired by the patient in early life. After five years as the primary love object of the mother, the patient suffered a partial abandonment when his mother remarried. His rage must have increased manifold when, three years later, he suffered further abandonment at the birth of a sibling. His mother as well as the stepfather directed the bulk of their love and attention to the sibling. He would have had to repress deeply his rage toward the new sibling and father by elaborate obsessional mechanisms, lest a tyrannical father take revenge upon him. Any show of hostility on the patient's part would have jeopardized his tenuous position in the family. After five years of dependency secured by his marriage, the patient was overwhelmed with anxiety upon the abandonment threatened by his wife. The discipline of army life was needed to reinforce his severely threatened obsessional defenses from overloading with anxiety and rage. Finally, his equilibrium was restored when his wife announced her decision to remain with him. After 13 years of marriage, his son displaced his position with his wife. The "rage" thus evoked threatened to erupt into overwhelming hostility directed toward son and wife. F.E. could not even hold his son lest his destructive impulses ascend to consciousness and action. Such impulses bring with them the fear of retaliation (compound-X poisoning and liver cancer). His own anxiety was fired by the current threat of a new abandonment and a return to the helplessness of childhood. All these stresses and conflicts occurred in the context of the patient's

application for higher professional status (namely, a new job) with the accompanying conflicts over power.

His psychosis became the psychological defense against being overwhelmed by rage and destructive impulses. He sought hospitalization lest he run amuck. In his early hospitalization, he frequently stated: "I feel like I want to hit someone or something," and would ask to be put into the seclusion area. Gradually, some of his rage was retroflexed, and depressive feelings became manifest. The therapeutic relationship was characterized by the patient's dependency upon his therapist and by his gratitude for the attention, encouragement, reassurement, and the granting of special requests for medication. Gradually the patient acquired sufficient reassurance to reestablish vocational and family relationships. Much of his dependency feelings were displaced upon his pills, upon which "I don't want to become dependent." His anxiety found expression in somatic symptoms. Gradually his wife let her husband reestablish his dependency relationship upon her, and he could relate to his son. Equilibrium was again achieved, and the obsessional defenses resumed their effect—the patient now works from early morning to late at night upon his chemistry.

Summary

1. The problem of postpartum psychoses in females is discussed.

2. A review of the literature on postpartum psychoses in males is presented.

3. Couvade is discussed as a psychological reaction of the father to childbirth.

4. Three cases of schizophrenic reactions in males precipitated by the birth of a first child are presented.

5. Possible psychodynamics are discussed.

Acknowledgments

My deep appreciation to Dr. Benjamin Balser for providing me with much help and encouragement as well as with Case II, and to Dr. Harry Reiss, who offered much valuable criticism.

[REFERENCES ON FOLLOWING PAGE]

REFERENCES

1. Ebaugh, F. G. Toxic and Organic Reaction types of mental disease. In *Oxford Medicine, VII,* New York, Oxford Univ. Press, 1949, pp. 259-334.
2. Hamilton, J. A. *Postpartum Psychiatric Problems.* St. Louis, C. V. Mosby Co., 1962.
3. Zilboorg, G. Depresssive reactions related to parenthood, *Amer. J. Psychiat. 10:*927-62, 1931.
4. Wainwright, W. *Fatherhood as a precipitant of mental illness,* presented at the meeting of the APA, May 1964.
5. Jarvis, W. Some effects of pregnancy and childbirth on men, *J. Amer. Psychoanal. Ass. 10:*689-700, 1962.
6. *Couvade,* Encyclopaedia Britannica, Chicago, 1958.
7. Devereux, G. Institutionalized homosexuality of the Mohave Indians, *Hum. Biol. 9:*498-527, 1937.
8. Freud, S. Psychoanalytic notes upon an autobiographical account of a case of paranoia (*dementia paranoides*). In *Collected Papers 8:*387-470, London, Hogarth Press, 1948.
9. Klein, H. R. and Horowitz, W. A. Psychosexual factors in the paranoid phenomena, *Amer. J. Psychiat. 105:*697-701, 1949.
10. Oversey, L. Pseudo-homosexuality, the paranoid mechanism and paranoia, *Psychiatry 18:*163-73, 1955.